COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: PHARMACY TAC

ZOOM MEETING

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April 14, 2021
1:00 P.M.
(All Participants Appeared Via Zoom or Telephonically)

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**APPEARANCES**

Ron Poole
CHAIR

Matt Carrico
Paula Straub
Rosemary Smith
Meredith Figg
Philip Almeter
Jill McCormick
TAC MEMBERS

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(Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

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AGENDA
(Continued)

MR. POOLE: It is 1:02 your time. The topics on the list here, I had a group of really good guys. I probably talked to five or six different people at different committees at different times to work on this non-sterile compounding and sterile compounding recommendation.

And what we finally came up with is - Sharley, can you share my screen or do I have to do it on my end?

MS. HUGHES: Let me make you a co-host and you can share your screen. I'll take mine down.

MR. POOLE: I want to keep coming back to the----

MS. HUGHES: But I'll have to stop Share in order for you to be able to share. You should be able to do it now.

MR. POOLE: Okay. Can everybody see this now, this S bar?

MS. HUGHES: Yes, a Word document it looks like. Yes, I see S bar now.

MR. POOLE: Okay. What we decided to do on this - I'm going to read this outloud and it's going to be in - I'll need somebody else to make it in the form of a motion, but the

situation is Kentucky Medicaid recipients need coverage for non-sterile and sterile compounded medicines to be reimbursed by the Department of Medicaid Services so they may receive the best drug therapy for their medical conditions.

Background: Roughly six years ago, different pharmacy payors in the marketplace exposed the fraudulent billing of compounded prescription claims by a minority of pharmacists and pharmacy owners across the country. Nationwide, payors ceased coverage for any compounded medications.

However, compounded medications may often be the preferred and best drug therapy for patients. For example: The University of Kentucky Medical Center uses various non-sterile compounds for their pediatric population - many times at a financial loss for the hospital - but it is in the best interest of the patient’s healthcare.

Myself, I treat children with autism spectrum disorders with nutritional non-sterile compounds that allow for supplementation of key nutrients that this patient population is generally deficient in, and I provide these at no cost to our Medicaid patients due to the lack of

existence of a reimbursement model for compounded drug products.

These are examples of common practices by Kentucky pharmacists to provide personalized medications at a financial loss so that Medicaid patients will receive the therapy they need.

This patient population cannot afford medications out of pocket. So, the alternative is that patients do not get their medicine and their health deteriorates. However, the current situation is not sustainable nor scalable.

Just as an aside here - I think most of us know that autistic children aren't deficient in Risperidone or Fluoxetine or any of the SSRI's. They're deficient in Glutathione, Manganese, Taurine, Selenium, Zinc, deficient in the essential fatty acids and that's what my compounds have in them, just to mention to you.

On the assessment, non-sterile and sterile extemporaneous compounds are necessary for optimal treatments. We need a compound reimbursement model in place where the claims processor and Medicaid are confident in paying for legitimate claims devoid of fraud or potential for fraud.

The recommendation that we would like to make to the PTAC which will then, in turn, recommend to the Medicaid Advisory Council:

1. Demonstrate the need for compounded medications by prescribers and pharmacists. We have doctors and pharmacists that can testify to these being the preferred treatment, especially in the hospital setting but also definitely in my instance and the community setting also.

2. Adopt a reimbursement model that eliminates or greatly reduces the potential for fraud. That's the problem that we're having to come up with is that, okay, how can we make sure that we come up with a model that somebody is not going to exploit because trying to protect or think about the payor.

That's what I would be thinking of, but, of course, we want that availability of that therapy for the patient. So, we've got to come up with a win/win for both sides.

3. Adopt a reimbursement model that reimburses based on fair market assessment, time to compound and expertise needed for compounding.

4. Compounds will consist only

of active pharmaceutical ingredients, excipients, bases or diluents compounded using only approved vendors. So, again, in order for an act for quality control and assurance is that there will be an approved vendor list where you can purchase from.

5. Compounds will only be made in an approved quality environment. So, there is not a situation where you can just open up a chemical in an open-air environment where it's not under a basic safety cabinet or some type of hood because of the exposure, that it can have a threat for quality of the product, plus a threat to the people around.

6. Compounds will be made using documented reproducible formulations.

Potential solutions is to work with a pilot project with Medimpact to develop the best reimbursement model aimed at eliminating or limiting fraud or create a Compound Formulary Committee for reviewing only extemporaneously compounded non-sterile and sterile products that represent the preferred treatment for individual patient needs that will result in savings to the Medicaid Program because there are many instances where a compounded product can be used for better treatment, get the patient back healthy again in a

quicker fashion, keep them out of the hospital longer, decrease their hospital stay that can save the Medicaid Program which should open a lot of ears.

So, I know it's not a definite solution but we just kept beating around and beating around ideas about possible accreditation or possibly creating a network that the payor and/or the Board of Pharmacy would be overseeing to make sure the quality is there, coming up with a business model that is fair for both sides and will not allow for somebody to bill fraudulently because obviously we have a past record of that in the last five years.

For instance, there was a $2.5 million fine levied against an Alabama pharmacist for his fraudulent billing to the - oh, come on - our federal government - for Armed Forces, the payor for that.

And, then, I thought they were going to be the top of the ladder and, then, a pharmacist in Florida was able to top that by getting a $4 million fine for his fraudulent billing to TRICARE.

So, anyway, the history is out there. We would like to come up with a model that will allow for both sides to be impacted positively,

and, by all means, the number one goal of this is to be able to get therapies paid for that are preferred by the prescribers in best treating the patient.

So, does anybody else have a comment about this document here and also the potential for somebody to make a motion to approve this to where I can present this to the Medicaid Advisory Council? I would really like to work with Medimpact on taking this further.

DR. ALMETER: I have a comment I'd like to make. I support this thus far, and I think having this, laying the groundwork for this allows us to position ourselves better.

I know at the University of Kentucky, there's a lot of research going into pharmacogenomics. One size doesn't fit all. It doesn't. And as the evidence comes out more, our hands are kind of tied right now with reimbursement.

So, if the evidence shows that doing custom compounding for Drug X, Y or Z has better outcomes, lower cost to the system, we need a mechanism in place just to do that. So, I'm supportive of this completely.

MR. POOLE: Okay. Thank you. Are there any other comments? Paula.

MS. STRAUB: I support it as well 100%. I have different providers that have reached out to me about this issue and how they're struggling to get pharmacies to compound their products. So, I support it 100%.

MR. POOLE: Okay. Would anybody like to make a motion because I cannot?

DR. ALMETER: Motion to approve.

MS. STRAUB: I second.

MR. POOLE: Motion by Philip, seconded by Paula. Those in favor, say aye. Any opposed? Motion carries.

I'll be presenting all these motions, recommendations, whatever we come up with at the next Medicaid Advisory Council meeting and I will work with Matt Martin and different people, and certainly we have - his name is Dan Phillip. I'm trying to remember his last name.

DR. ALMETER: Dan Grantz.

MR. POOLE: Yes. Thank you. I'm certainly going to be working with him. He is working on the numbers part of it to see what kind of price tag that UK Med Center is - well, let's just put it bluntly - eating in order to treat these patients. So, he's working on that. He's also

working on testimony from his prescribers.

So, anyway, we'll have a good way to support this document moving forward.

MS. HUGHES: Ron, could you send this to me?

MR. POOLE: Yes, I will. At the very end of today, I will send you all of these and I'll have them marked on which topic and everything.

MS. HUGHES: I think we've missed a couple of things on the agenda before you go forward. It's Approval of Minutes and, then, I know Jessin has got a couple of folks he wants to introduce.

MR. POOLE: Okay. I'm sorry.

MS. HUGHES: No, you're fine. I just told the Medimpact folks that we've got to get them on early in case they needed to leave but they may stay the whole meeting.

MR. POOLE: Okay. Well, real quick, I don't have the minutes pulled up and I'm not sure that we had a good copy of the minutes, Sharley, but that's my fault.

MS. HUGHES: I sent them out. I sent the transcript out.

MR. POOLE: Okay. So, do I hear

a motion to approve the minutes?

DR. ALMETER: I motion to approve. I saw them.

MS. McCORMICK: Jill McCormick. I'll second.

MR. POOLE: Second by Jill. Any further discussion? All those in favor, say aye. Any opposed? Okay.

Let me turn it over to you, Jessin, for introduction of your guest, please.

DR. JOSEPH: Hey, everyone. This is Jessin. I did want to take a quick second to introduce Dan Yeager who is with Medimpact.

Dan and I and the rest of our pharmacy team here at Medicaid and his team at Medimpact have been meeting I would say hour by hour at this point to make sure that we go live for 7/1.

I did want to give Dan, again, a chance to introduce himself and, then, Dan, if you wanted to just give kind of quick updates on communications and where questions may be able to be fielded, I think that would be good for this group, and we'll make sure we do the introductions for the rest for the TAC meetings as well.

MR. YEAGER: Thank you, Jessin.

Good afternoon, everyone. Again, this is Dan Yeager. I'm the Account Director for the State PBM. I'm a pharmacist. I live in Lexington, Kentucky.

Medimpact certainly looks forward to working with this committee and really the community of pharmacies and pharmacists throughout the state.

We are very busy working on the implementation, as you can imagine. We think that it's going to be very important that we keep pharmacists in the know, as well as the other providers in Medicaid.

So, we have some dates that I'd like to share with you so you can look for things in your email box. First of all, this all starts on July 1st, as you probably know.

We've had one mailing that has gone out to pharmacies, and on that mailing, there was a list of dates for webinars and our first webinar is actually going to be held tomorrow. I'll have a short presentation where pharmacists can see that and, then, they can ask questions as they come up.

We'll have another pharmacy mailing on May 1st which will have more information

about claim submission and BIN numbers and PCM's, the things that pharmacists need to get those claims paid.

On May 14th, we'll have another webinar to pick up any other questions that folks may have. There will be another mailing in June, on June 1st. Again, we're building the amount of information needed so that pharmacies can successfully fill prescriptions.

We'll have one more web-based call on June 15th. So, that's a couple of weeks before go-live to answer any outstanding questions that pharmacists may have.

We'll have something similar to a war room available on July 1st on the go-live date. Our Technical Call Center will be available for the pharmacies and our Pharmacy Help Desk will certainly be operational and available to answer questions and help pharmacists get claims paid, but we'll also have an escalation point into this war room. So, if there are major, outstanding issues, then, the folks there will be able to solve those.

And, then, after July 1st go-live, on July 15th, we'll have another webinar where we'll see what questions after go-live that

pharmacists have.

So, that's kind of our communication strategy for pharmacy. We're doing things in advance and then afterwards, and we hope that will answer the majority of questions that you guys will have.

MS. STRAUB: This is Paula Straub and I have a question for you, Dan. I am not a dispensing pharmacy. Would it be possible for the PTAC members to get a copy of those communications, and specifically the webinar information for tomorrow so that we can attend as well?

MR. YEAGER: So, can I send the members of this committee the presentation and the first communications that have gone out? Absolutely, yes.

MS. STRAUB: Okay. Thank you.

MR. POOLE: That would be really helpful.

MS. HUGHES: Dan, if you want to send them to me, I can get them out to the PTAC members if you'd like. And any future communications that you have going out to pharmacies, if you want to send them to me, I'll make sure the Pharmacy TAC gets them as well.

MR. YEAGER: Okay. And this is? I'm sorry.

MS. HUGHES: I'm sorry. This is Sharley at DMS. I sent you the meeting invite.

MR. YEAGER: Okay. I sure can, Sharley.

MR. POOLE: Does anybody else have any other questions for Dan?

DR. MUDD: Ron, this is Ben Mudd with KPhA. Sharley, would it be possible to add other people to that list because I'm in a similar situation? It might be easier instead of Dan sending it to multiple people, can you add KPhA to that list that you would send out the information to?

MS. HUGHES: We can probably get Jessin or Fatima to send it out to the Kentucky Pharmacists Association.

DR. JOSEPH: Ben, this is Jessin. Dan, if it's possible, when you send it to Sharley, can you just send it to Ben as well?

MR. YEAGER: Sure.

DR. JOSEPH: And I think you guys have each other's emails. If not, we can connect you guys.

DR. MUDD: That would be great.

Thanks, Dan.

MR. POOLE: Obviously, Dan knows every bit of communication is going to make their war room on July 1 a lot easier if everybody communicates.

MR. YEAGER: I'm hoping we don't have any calls but I've been in this business a while enough to know that we'll have a few; but anything we can do to minimize that, that will be great.

MS. HUGHES: Dan, KPhA has helped us in the past with them sending out email blasts with information from the PBM's.

DR. JOSEPH: Thank you, Dan. Thank you, Ben. Chairman Poole, thank you for the time.

The only other thing that I would add in terms of communication, and I think everybody in this room knows this, I think it's interesting to see how well all pharmacists know each other in this state and word of mouth does travel well.

So, if you can communicate with your peers as well, the ones that may not be checking those Zoom boxes and those fax blasts, because I understand that everyone is always busy and, again,

we are a payor in the state and I'm sure you all work with multiple payors.

So, just as important as us sending out these formal ones is it being a formal word-of-mouth communication that I think you all are very good at doing already. So, if that is also able to be kept up, I would sincerely appreciate that.

MR. POOLE: Okay. Dan, are you still on here?

MR. YEAGER: Yes.

MR. POOLE: Did you graduate from UK in '89?

MR. YEAGER: I did.

MR. POOLE: I graduated in '90. So, I was hoping that was the guy I knew.

MR. YEAGER: Yeah, I'm an old-timer.

MR. POOLE: Okay. Jessin, did you have anybody else?

DR. JOSEPH: No. That was it for me.

MR. POOLE: Okay. Also, Jessin, did you want to elaborate on your future and like when your last day will be, or do you know yet?

MR. JOSEPH: I do know but I was

planning on waiting until the very end.

MR. POOLE: That's fine. I'm sorry.

MR. JOSEPH: I can do it whenever you feel is more appropriate.

MR. POOLE: We'll just do it at the end on that. That will be fine.

Sharley, if you will put the agenda back up.

MS. HUGHES: You'll have to stop sharing.

MR. POOLE: Stop sharing.

MS. HUGHES: Is it not letting you?

MR. POOLE: I've got the agenda the rest of the way. We're already done with Number 1 and 2. I've got mine in the same order, just a little bit different format.

So, now the topic of the appeal process. The people assigned to this committee or worked on it was Jill McCormick, Matt Carrico and Rosemary.

I did have something sent to me earlier that basically the current MAC appeal process since Kentucky has a MAC law. Is there anything

else, Matt or Jill or Rosemary, that you all want to add to this?

MS. McCORMICK: I was going to actually defer to Matt. This is as NACDS looks at states that have strong language, Kentucky came up as one of the states that we point to for other states. So, this is what I recommended to Matt and Rosemary and they concurred with I think a few edits.

Me not being a pharmacist and not doing this every day but being a government relations' person, I am going to defer to Matt and Rosemary for those kind of detail-oriented comments.

MR. POOLE: Okay.

MR. CARRICO: As far as the appeals process goes, Kentucky does have a good one and fortunately they define MAC as how a generic drug is reimbursed. So, that was a way to get around for PBM's trying to switch terminology.

So, anyway, a generic drug reimbursed is MAC; and at the moment, we feel like the current process is sufficient.

And if there comes to be a point where we're starting to see NADAC isn't really aligning with what the current market is, then, we can take another look at the appeals process; but

right now, we think everything is in place to make this smooth and hopefully it stays that way.

MR. POOLE: Okay. Dan, if you don't care to make a comment on your all's appeals process or I guess how it will be put together in case there are issues that we need to appeal.

MR. YEAGER: Ron, we take all of our pricing cues, if you will, or process from the State. And, so, Jessin, I don't know if you want to answer this.

DR. JOSEPH: Ron and team, the appeals process here for drug pricing, for ease of implementation, we are moving forward with the fee-for-service reimbursement methodology, right?

So, the same appeals process that we have in the fee-for-service methodology is what we would be applying with Medimpact.

So, if a NADAC reimburses too low and that is what the lowest of logic is according to the State Plan Amendment and what we put into the reg, then, the appeal process there is to alert the Myers & Stauffer team at CMS that, hey, this NADAC is not appropriate and, then, to determine whether or not research is necessary to change that rate.

Those files, those effective

dates of those rates change based off of - I think everyone is aware that the NADAC does have a lag - but they do change if they do identify that a change is warranted.

So, those files are then updated and a new effective date of the new rate is put back in and that's what would be loaded into our systems.

So, again, it's not that we control that rate. The State doesn't own that rate and technically CMS doesn't. I guess CMS contracts for that rate but that rate is a nationally publicly available rate and those files are maintained by the federal government.

So, I don't want to say that we can change the NADAC because we certainly can't, but the steps necessary that we use in the fee-for-service model is to research the price before any changes can be made.

And, again, if the lowest of logic hits the federal upper limit or if it hits the WAC, then, really, there's no control that the State has to adjust the federal upper limit and definitely not to WAC because that's going to be controlled by the manufacturer.

Again, at that point, really, the price that we're talking about is just the MAC appeal, right, and the same process that we have with Magellan which is a pharmacy would have to submit their request form for a MAC research request.

And, then, the PBM that we contract with, which is, in the case of the MAC, which right now on the fee-for-service side is Magellan, would have to do the research to determine whether or not that MAC price is affordable in the state and available by a vendor.

And, then, we would review on our end if it leads to a second review, but, theoretically, that call is then made after the research is done.

So, there is no change to the process. At the end of the day, it is what we already do in fee-for-service and that's what we would anticipate with the managed care plan and Medimpact as well.

MR. POOLE: And, Jessin, I would just add there that the person that is going to be taking your place, if they had an understanding of when you say if it's available in your marketplace. Well, if I have a primary vendor with McKesson, I

don't have a contract with AmerisourceBergen or Cardinal.

Now, if it is a secondary, then, yes, I have a greater chance of being able to have access to that; but, still, it seems like there's as many secondaries as there are days in the year.

So, sometimes it may be available but it may not be available to a certain pharmacy. It could be a chain. It could be an independent. It just depends.

And I know you're aware of that, but I just would really like that to be passed on to the next person to where they understand the logic behind this isn't available to everyone.

DR. JOSEPH: Sure. Yes. I mean, certainly. To that extent, I think we've evaluated certain products that we know have an incorrect MAC and we've made the changes necessary in our system - I mean, I can only speak for the fee-for-service side - where we have, then, adjusted our logic and where we need to go, or at least adjusted the MAC price.

So, I don't necessarily think that's new to the industry, but I would say that we would be hesitant of saying if we see it available

somewhere, then, we have to take - it's a case-by-case scenario, right?

I can't necessarily say that every single one we're going to necessarily agree to because there are going to be cases, and I think we're just being realistic here, where a MAC price may be lower than what the pharmacy buys it for.

But, again, this is where the dispensing fee hopefully is enough to make up for that loss and that it isn't a loss where we're talking in the - like I say, I don't know what the number would be on a per-prescription basis, but it would not be to the extent that it's detrimental, but I'm trying to be realistic about the fact that it will likely occur and that research would be necessary.

MR. POOLE: And you bring up something, Jessin, that I've not had anybody else come up with this topic, but I've been saying for years on the appeals process that the manufacturers have to be informed and have to take an active role in this appeal process because sometimes they're the only ones that can truly change the figures and change the numbers.

And I've never understood why a

PBM takes on the bigger role when a lot of times their hands are tied, too, to a certain index and really it's the manufacturer that needs to be informed that, hey, we just had this week - I'm just guessing but I'm just throwing out a hypothetical - hey, we just had a thousand people submit an appeal on this drug of yours that they're under water on. Why don't you take a look at that and let's discuss what remedies we have.

I've often said that, to me, that would be the easier way and the direct way to deal with some of these appeal issues where the PBM's sometimes, they can't change whatever index, the lower of logic.

DR. JOSEPH: Again, the model that we're going towards is not your normal commercial model obviously because we're using more transparent pricing, I would say, but I think there's probably more to that, Chairman Poole. I'd be glad to speak to you maybe off this meeting to kind of get into the weeds of that.

MR. POOLE: Okay. That sounds good.

Anybody else have anything further to add on the appeal process? And I didn't

thank my staff or my subcommittee members in the first one, so, I apologize for that, but Matt Martin and Daniel Grantz and A.J. Day and all those guys, I just want to thank them.

I want to thank Jill and Matt and Rosemary. Rosemary has already apologized for not being able to be real active here, but when your store is - one of her stores is literally under water, we understand, and that's what has been taking all of your time, but thanks for everybody working on that.

Is there anything else to add on the appeal process?

Let's move on to Item c, then, the reimbursement per prescription guidelines. That's Paula and Matt. I've highlighted the comments that I got in an email and just wanted to let you two elaborate on it.

MS. STRAUB: This is Paula. I contacted several pharmacies, specifically pharmacies that were doing Suboxone prescribing, as well as behavioral health drugs, and they, too, mentioned that they will dispense these medications several times a month through no fault of their own. It's the prescribing prescriptions they get from the

providers, but they do believe that a dispensing fee for those prescriptions is necessary.

So, that's really all the feedback I had. I don't know if Matt had any additional feedback.

MR. CARRICO: Mine is very similar to what Paula said. Not only is it doses getting changed, especially the Suboxone, but it had to do with in my area nurse practitioners or other prescribers having people come in every two weeks because they basically wanted to do pill counts and stuff like that.

So, a lot of controls are prescribed in two-week quantities. So, that would really have an effect on the bottom line if you're only getting paid once every twenty-three days.

So, I think it needs to be seven days. If we're going to put a limit on it, seven days would be the most.

MR. POOLE: Okay.

MR. CARRICO: I understand Medicaid is concerned about people trying to milk the system, but I don't think it will be very difficult for them to kind of see who is milking the system.

If someone is just filling one

Lisinopril a day for thirty days straight on the same prescription number, you'll be able to kind of pick up on that pretty quickly.

MR. POOLE: And if you want to send a red flag up by doing something so ridiculous, then, that's where an audit process is justified.

MR. CARRICO: Correct. So, I'll make a motion to lower the dispensing fee from one every twenty-three days to one every seven-days.

MR. POOLE: Motion by Matt.

MS. STRAUB: Second.

MR. POOLE: Second by Paula. Any further discussion? All those in favor, say aye. Any opposed? Motion carries. And, again, Sharley, I'll get that to you.

MS. HUGHES: Thank you.

MR. POOLE: And, then, for the audit policy, I had Jill, Matt and Rosemary working on that, and thank you all for doing so.

I'll go ahead and switch to this. I'm assuming by looking at your changes, that you took the current audit law and - you all just tell me what you did here.

MS. McCORMICK: I'm again going to defer to Matt because it looks like he made - I

sent, again, Kentucky's audit law. So, Matt and I took a look at that.

He made some changes and it looks like I sent you the version that didn't have all the changes accepted. So, they're in different colors. So, Matt may be able to point to where he added something that wasn't already in the Kentucky audit law.

MR. POOLE: Okay.

MR. CARRICO: One change was the way they're going to audit you. Instead of sending you mass numbers where you don't see the end of the numbers they're going to audit, they send you what they're going to audit ahead of time, preparing for an audit is usually three-fourths of the battle, getting things pulled out in time. So, that was the change.

Another one was if for some reason an audit, they have to check the doctor's notes and they don't match what the pharmacy has, a doctor can sign an affidavit. The main reason for that is all the time, you will call a doctor and say this isn't covered, can we switch to this. Yeah, okay, sure. And you assume they document it, but, then, they send you the same old prescription the

following month on EScribe and you have to call and remind them again.

So, it's more to protect the pharmacy. In case a doctor's office didn't correctly document on their end, they can sign an affidavit saying, yes, that's what they should have done and the pharmacy did it correctly.

Those are the main two big points, if I remember correct, in trying to go through this real quick.

I think it was already in there but the invoice audit part and that they're not going to be able to do those without any real reasons and that was the main part.

MR. POOLE: And with this, just to let everybody know, I mean, obviously, this will take working with a legislator on looking at this.

And I know Steve Sheldon had a bill that he pulled due to late in the Session and it did address some of these issues, Matt, but we will definitely need to work with Ben at KPhA to come up with a consensus on any changes that we need to make in the audit law and, then, obviously look at people like Dan Bentley and Steve Sheldon, Robert Goforth and, then, the three - Representative Bowling - I'm

trying to remember them all.

There's three pharmacy owners that aren't pharmacists, but, anyway, look at basically the pharmacy caucus and let them be well-informed of the changes we'd like to see and see if Steve Sheldon can incorporate that into his new bill that he's going to present.

MS. HUGHES: Ron, just as an FYI, this is a Department of Insurance statute. There's nothing that Medicaid can do with that. That's not a Medicaid statute.

MR. POOLE: Okay. So, you're saying it pertains to - okay.

MS. HUGHES: Pertains to commercial insurance.

MR. POOLE: Commercial plans only. Okay.

MS. HUGHES: Most of the DOI regulations do not apply, I don't believe - I mean, some of them we incorporate into the RFP and stuff but this is not a Medicaid statute at all. The 304 is Department of Insurance.

MR. POOLE: Okay. You're right. So, let me ask either Dan or Jessin or what-have-you. If we did have some audit concerns, I guess we would

just work with the Department of Medicaid on, if there were some issues that came up, that we would just work directly with you. Would that be the best mode of action there, Jessin?

DR. JOSEPH: Yes. You wouldn't necessarily be working with the DMS pharmacy team. Our audits are conducted by - well, we contract with Medimpact to do on-site and desk audits, but we also have audits completed by our Program Integrity Department. And, so, that's who you would be working with.

But to Sharley's point, I don't know if there's value of us reviewing a DOI reg and then getting a recommendation because there's nothing really we would be able to do with that.

MS. McCORMICK: So, I think what we were looking at is that we like the elements that are in the Insurance reg as far as the parameters around audits. So, we were thinking that these concepts could be applied to Medicaid under the new single payor system.

MR. POOLE: Well, again, it's going to be limited to what was in the RFP. So, Jessin, I don't know if you can elaborate on that process that talked about the audit process in the

RFP.

DR. JOSEPH: Yeah. I guess to that extent, we would work with Medimpact about the specific items that we're going to be auditing on. I couldn't tell you right now which of these provisions or which of these concepts we would consider versus not consider; but to Sharley's point, there are certain items from DOI that we pull and certain items that we don't because certain Medicaid audit provisions allow us to do different items and focus on different items.

So, there may be certain items that are federally required versus statutorily required, but, yeah, I'm not sure if that answers your question.

MR. POOLE: It does. I just didn't know if you remember any specific provisions in the RFP concerning audit with Medimpact or anything that sticks out that was different than what's been done in the past.

DR. JOSEPH: So, maybe I can talk a little bit more high level. I think, Ron, one thing that you had brought up was pharmacies get audited every right way from the MCOs for Medicaid specifically.

And I think we took that when we were putting together the RFP and it was that Medimpact would be the sole auditor for the state's pharmacy network; and to that extent, we would work with Medimpact about what those audits consist of. Again, some are federal, some are statutory and the others are deemed by the Medicaid system.

So, the concern around getting audited multiple times for maybe the same issue or whatever it may be, I think we've alleviated that because, again, the majority of these would be run by Medimpact with the input of our Program Integrity Department.

Now, the MCOs will still be monitoring claims. Obviously, it's in their best interest to do that. And at that point in time, they would be involved with us and the Medimpact team to then determine which pharmacy they want to choose and either desk audit or provide an onsite audit at.

So, I wouldn't say the MCOs are not involved because, again, it's in their best interest to know what's going on for their own members at the pharmacies; but from an auditing entity standpoint, all that would be stemming from DMS and Medimpact.

MR. POOLE: And, Matt and Jill, what work you all did on this, this is not wasted because, again, on the commercial plans, I would certainly be willing to work with Dan and just forward your thoughts certainly to our Government Affairs Committee, too, on the changes that you see would be effective moving forward on the commercial side. So, it's not that your work went to waste, okay?

MS. McCORMICK: If this law exempts Medicaid, then, really, I mean, what you would do legislatively is remove the provision that exempts Medicaid, right? I think that would go under the appeals, but this audit, as was mentioned earlier, is in the Insurance folks and applies to commercial.

MR. POOLE: Right.

MS. McCORMICK: So, sorry if I'm repeating myself. I'm just trying to make sure I understand.

MR. CARRICO: No. You're exactly right.

MR. CARRICO: One thing I would hope that Medimpact would implement, what you see sometimes is if something is getting billed that

looks suspicious, or not suspicious but it's outside the norm, the dosing or what-have-you, shows up, that they would call the pharmacy and be like, are you sure you're billing this correctly? I mean, I'll do it sometimes when we have - I can't bill decimals. So, if we have a 28.35 gram of Clotrimazole, someone will accidentally bill it for 30, thinking it's 30 grams and they're billing for 30 boxes, the insurance company will call and say I think you messed up and they're correct, we did, and we fix it realtime and it saves a future audit.

I hope that that becomes more of a regular thing to help protect us instead of insurance companies letting it slide and thinking they're going to get this money back. I just don't want audits to become a line item for Medicaid like they are for some insurance companies.

MR. POOLE: And Matt is exactly correct. It sure would be nice to not have what I call fishing expeditions when they're supposed to be given random sampling on a desk audit or something. If there truly is a mistake made, to be able to pick that up, they can pick it up very quickly and letting us know and we can get that corrected.

But, otherwise, certainly I

understand if there is suspicion of true fraud or illegal activity, by all means, I expect an entity to set up shop and do their auditing and properly prosecute or whatever they need to do.

But those of us who are trying to do the right thing, it would be nice to be informed of the one-offs that we can correct very easily in order for us to have reduced audits because it does, unfortunately, take a lot of our time on these desk audits when really there's no - we can't find any rhyme or reason why they're being assigned to us other than just what I call fishing expeditions is trying to find some mistake somewhere.

MR. CARRICO: And we all know when you're training a new technician to enter on a computer, there are going to be things entered incorrectly and pharmacists are humans. Sometimes they will get past them and it's not on purpose.

So, getting caught that way would be much better than being finding out you did it wrong in an audit.

And, also, Ron, I think Rick Slone wanted to say something.

DR. SLONE: Thank you. Real quick, I had a couple of questions just from a

historical perspective.

Under the current system, I got audited by CVS Caremark. The Department for Medicaid was not - they worked real hard and I worked with them closely but really I had to go through the DOI under Senate Bill 117.

And, then, the next process was a complaint to the MCO if I thought the results of an audit were unfair. And thank goodness that Senate Bill 117, the Department of Insurance really helped me out on that and I got of lot of the recoupment back.

My question is, under the new system, and I guess Jessin can answer this, too, and I think under Senate Bill 50 that the Department of Medicaid will be in charge, meaning if you have a complaint, you can go to the Department of Medicaid if you have a complaint with an a audit or anything like that. Is that correct?

And also if that's the case, wouldn't Medicaid, then, determine - will they be determining what parameters audits will be set? But, of course, under the old system, we would be going under the current commercial, as it is a commercial plan other than fee-for-service.

DR. JOSEPH: Dr. Slone, I missed that last part. Can you repeat yourself? Sorry.

DR. SLONE: Currently, if we get audited currently under the current system, it would fall under Senate Bill 117 which we would appeal to the Department of Insurance.

Under the new system, with one PBM, would we appeal anything to Medicaid? How will that process work? Do we go to Medicaid or do we appeal back to the MCO or the initial appeal would be with the PBM?

DR. JOSEPH: If you run into an issue, there is the ability to provide a grievance to Medimpact.

But I think big picture-wise, if there is something outstanding that it's not individual and a lot of the pharmacies are seeing this across the board, that's where mediums like this come into play where we can take that information back and discuss with Medimpact or with Magellan or whoever it may be about how to then reassess what we need to get done.

But I think you still do want to follow the initial process which is file the grievance as necessary, but, again, that's

situational, too. So, it depends on what it is and what you're filing for and DMS would always be here to listen.

DR. SLONE: So, we would appeal under the new system under the - we would appeal first to the PBM and, then, to Medicaid or we would appeal to the MCO? That was my question, or will it change or will it be similar to the way it is currently? I guess that might be a better way to put it.

DR. JOSEPH: Yes. So, there is a slight change. Again, it all starts now - and maybe this is how you already do it - but for us, this is how I'm looking at it. It starts with starting with reaching out to the Medimpact team and, then, we would be able to route it to DMS and, then, with the MCOs as necessary. And usually for grievances, it's not something that we take lightly.

So, it would certainly be passed over to the MCOs as well, but, then, we would expect whatever the situation is to be followed through and resolved at some point. Did that answer your question?

DR. SLONE: I think so.

MR. POOLE: Anybody have any

further comment on d, the audit policy?

Moving on to Item e, Medicaid P&T recommendation for OTC medications or even supplements, and that was Paula and Meredith. I was supposed to help with that and vaccinations has taken so much of my time. So, I apologize to Meredith and Paula. So, I put out this email. So, I wanted to allow either one of them to comment.

MS. STRAUB: This is Paula. I've had several providers reach out to me about the formulary, the OTC formulary, feeling that it's a supplemental formulary under each of the MCOs and that maybe it's not robust or not what they're used to.

I had a specific provider reach out to me and she's a pediatric provider. She specifically reached out to me about the coverage for emollients.

And as you can see, she referenced that eczema is one of the most common chronic illnesses for kids and that she felt like there was really not good access to emollients, and she asked if we could ask DMS to reconsider adding one or two emollients to the PDL. Specifically she mentioned CeraVe, the Vaseline, to be added to the

PDL. So, that was her recommendation to the committee and I'm just passing it along.

MR. POOLE: Okay. And, Jessin, obviously, as far as I know, you and anybody else from Medicaid are the only ones who have seen or know what's in the RFP obviously besides Dan Yeager on this call.

So, when it comes to possible expanding the OTC medications or even supplement list, I know your limited future here, but what do you see as a good recommendation or a good possibility of being able to - maybe the Medicaid P&T does address this or maybe there's a subcommittee of OTC and supplementation or just give me your opinion on it.

DR. JOSEPH: Sure. Fatima is on. Fatima, she's our pharmacist here at the State. She is our Associate Pharmacy Director and she has been working with the Managed Care Organizations for the 7/1 go-live date of a revamped OTC list for Medimpact to implement into the system.

I would say that from a PDL perspective, if it's an OTC product, we don't necessarily consider that a PDL product. Sometimes an OTC product might fall into the PDL, but we do

generally think of them as two separate because it can obviously still be bought over the counter, and we could consider adding a class to the PDL but that's not something that - that would require us to take a hard look at what the class specifically requires.

So, there is a difference and I would say that we are evaluating the OTC list entirely. We also understand that the MCOs have currently different OTC lists and that was very evident in what we were looking through.

And, again, for moving forward on 7/1, what we would like to do is have a publicly searchable OTC list as well as an aligned one for all of the MCOs.

So, it would be one pharmacy benefit design entirely and hopefully that would answer some of the questions and concerns across the board.

I will say that we will take this one back and take a look at what we're looking at right now and see if this is addressed already or if we need to make any additional changes, but I would say that we are looking at this and we are aware of this right now.

MR. POOLE: And, Jessin, how often or does the Medicaid P&T meet on a regular basis because I certainly feel that, again, a lot of these OTC's, they're either not going to be - they've been used to either getting them in the past because it is a little bit leaner than some of the MCOs in the past, or if there is a need, is that the body you feel that we need to go to?

DR. JOSEPH: So, you certainly can bring it up to the P&T Committee if it is a product that would fall under a PDL class.

So, again, the PDL classes are posted publicly. The products within each class are posted publicly. So, if you do identify where a product needs to fall in or if there is an issue with a product that's already in a class, then, certainly, by all means, please bring it to P&T.

However, if it is not a product on a PDL class, then, this is the medium and outreach to the Department is where you would want to start that conversation.

We can then take it back and determine whether or not we need to add the class to the P&T Committee. Is there value in doing that, or is there value in just opening up the class entirely?

That's something we do internally. And, again, the P&T members get to see that from a cost perspective if we do make it a class, but sometimes it is just more logical for us to open it up entirely because there are generic products on the market. There are a number of labelers that already agree with the Medicaid Rebate Program and, then, it just takes us to implement it. So, there's two ways you can go about that one.

MR. POOLE: Okay.

DR. FIGG: Ron, this is Meredith. I like the idea of a more unified, searchable list for over-the-counter products. What Jessin described seems like a good solution.

I do caution. I reached out to some firms in Ohio and Pennsylvania. It seems like they have such a list that's searchable. Again, I caution on it being too robust and that it being something that can be taken advantage of and drive up costs.

I have the same concern with an every-seven-day dispensing fee as well.

DR. JOSEPH: Certainly.

MR. POOLE: Okay. Does anybody any further comments or want to take any action on

this particular topic? I think it's more of a discussion.

DR. JOSEPH: Ron, I probably need to give you a clarification because I think you said only Dan and I have seen the RFP. The RFP is available online. So, that should be available if anybody on the PTAC needs to take a look at that.

MR. POOLE: Okay. All right. Thank you.

Hearing no further comment, I will turn it over to you, Jessin.

DR. JOSEPH: I think Ron alluded to it at the start. My last day with the Cabinet will be this Friday.

And, so, I will be leaving, but I think everyone is in good hands in terms of making sure that we go live 7/1, ensuring that we adjust the reimbursement methodologies, consider all the recommendations put together by the PTAC and the MAC.

From my standpoint, again, I think this is a medium that should be used for recommendations, for constructive conversation about what we can and cannot do.

So, I do sincerely appreciate everyone's participation and allowing me to at least

point out from the Medicaid's state side perspective of what we can and cannot do.

So, to that end, again, it's been a real pleasure. I can't thank everybody enough. Every time I get into these meetings, I recognize so many names. Again, thank you.

MR. POOLE: Jessin, you will certainly be missed. I appreciate your candor, your knowledge. The toughest I guess in my thirty-plus years of working with the State or even federal or whatever, any kind of bureaucracy is that when you have a change of people in those positions because you try to develop a good rapport and a good line of communication.

So, I appreciate that you're a straight shooter and I'm going to miss the fact of being able to call on you, but hopefully we'll get somebody in your place that's well-qualified and we can develop those relationships and get the cooperation going there, too, but thank you so much.

MR. CARRICO: Jessin, this is Matt. I also want to thank you for all your hard work over the years. It's been a pleasure to get to know you and to get to work with you and best of luck in your future endeavors.

MS. SMITH: Jessin, this is Rosemary. I would also like to thank you for all the many efforts you've made for pharmacy since you've been here and you will be missed. Thank you, Jessin.

DR. JOSEPH: I appreciate that, everyone. Thank you very much.

MS. HUGHES: DMS is going to miss him, too.

DR. THERIOT: Yes, we will.

MS. HUGHES: But we have had Fatima working with him for almost a year.

DR. JOSEPH: Not yet. Eight months but she is a very fast learner, I'll tell you that much.

MS. HUGHES: We will miss him but at least it's not bringing someone completely new to Medicaid. We've still got Fatima that has learned from Jessin and will be helping us out.

I don't know what the plans are as far as replacing Jessin, but do know at least we've got - it's not like we're starting off brand spanking new with somebody. Jessin has done well for us.

MR. POOLE: Yes, he has. Okay. That is all on my agenda. Thank you all very much.

And, again, Sharley, I will be sending you a couple of bits of information that you requested.

Thank you all, and, like I said, I will be presenting the two passed motions to the MAC the next time it meets, and we'll just be in touch on any other issues.

And certainly I want to allow Dan Yeager to reach out to me anytime he wishes to on anything that is of concern that could make pharmacists more comfortable with this change starting in July. So, certainly, if at anytime you want to reach out to me, Dan, that's perfectly fine, and certainly we can get working on any issue.

MR. YEAGER: Thank you, Ron. I may take you up on that.

MR. POOLE: All right. Thank you all very much. Have a good afternoon.

MEETING ADJOURNED